Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

Africa faces difficult choices in responding to COVID-19

Coronavirus disease 2019 (COVID-19) is now established in Africa, with more than 63 000 cases and 2200 deaths in 53 countries, as of May 11, 2020.[1] Fragile health systems leave African countries vulnerable to the anticipated surge in severely ill patients with COVID-19, despite much younger populations.

To flatten the curve, some African governments have imposed stringent public health measures (lockdown) based on physical distancing to reduce transmission. However, the safety of this approach in poor communities has not been evaluated, and it is plausible that lives lost to lockdown could exceed those saved from COVID-19. Potentially fatal unintended consequences include widespread economic disruption and hunger, worsening food insecurity if harvesting is disrupted, and increased domestic and state actor violence. Large numbers of African patients with HIV and tuberculosis depend on functional health services, with substantial individual and public health consequences if treatment access is disrupted.[2] Although anticipated by national programmes, some treatment interruptions are inevitable during prolonged lockdown.

With clear understanding of risk, governments can make informed decisions about harms and benefits. We used Spiegelhalter's approach to compare age-group specific infection fatality ratios from COVID-19 to background (non-COVID-19) mortality risk in Malawi, South Africa, the UK, and India.[3-5] This assumes COVID-19 infection fatality ratios similar to China, but true age-specific case-fatality rates might be higher with fragile health systems. For context, Malawi has not yet triggered lockdown, whereas the UK, South Africa, and India have. We estimate that in the UK, having COVID-19 confers risk of death equivalent to approximately 12 months of background mortality risk, averaged across all age groups. By contrast, in Malawi this risk is equivalent to 4 months of background mortality (appendix). This reflects higher background mortality rates in Malawi, underscoring the fragility of health under normal circumstances.

Malawi (median age 17 years) also has relatively few older citizens, with 6·6% of the population older than 60 years. This makes alternative strategies potentially safer and more feasible than lockdown—eg, community-led approaches to support older people to self-isolate with provision of food, medicine, and wellbeing support.[6]

Although we fully agree that macroeconomic arguments against lockdown cannot justify widespread loss of life in Europe and Asia, the considerations are very different in Africa, where lockdown could cost many lives. We urge African governments to carefully contextualise safe physical distancing policies that maximise likely benefits. Without a context-specific, ethical approach to physical distancing, unintended harms from stringent lockdown could pose more harm than the direct effects of COVID-19 itself.

We declare no competing interests.

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Published **Online**
May 12, 2020
https://doi.org/10.1016/S0140-6736(20)31056-4
See **Online** for appendix

Where are the ECDC and the EU-wide responses in the COVID-19 pandemic?

Published **Online**
May 13, 2020
https://doi.org/10.1016/S0140-6736(20)31132-6

As the EU continues to face the COVID-19 pandemic, an unprecedented transboundary crisis, its member states resort to measures within the boundaries of the nation state. This situation questions the capacity of the EU to deploy public health instruments to cope with pandemics. One such instrument, the European Centre for Disease Control (ECDC), seems to show a discreet involvement in this crisis, suggesting emerging isolationist behaviours of the member states.

The ECDC was established in 2004 with a mandate that aimed to "identify, assess and communicate current and emerging threats to human health from communicable diseases".[1] However, such a mandate was not complemented with enough resources to help the ECDC become a European knowledge hub in communicable diseases. To put this into perspective, the US Centers for Disease Control and Prevention (CDC) have legal powers and cover a greater range of public health areas through bodies such as the National Institute for Occupational Safety and Health or the National Center for Health Statistics. The CDC also has a much larger budget than the ECDC (approximately US$8 billion for 2020,[2]

whereas the ECDC received €60 million[3]) and staff (10 796 employees in 2018,[4] whereas the ECDC employed 271 people that year[5]).

The ECDC was established within a context that involved inconsistent national laws on pandemic planning across the EU member states, which already had their own institutes and agencies of public health.[6] In fact, it has been noted that the protectiveness of member states concerning their national privileges sometimes blocks agreement on practical and collective measures.[7]

In our research on the role of EU agencies in crisis episodes, we described how the low cooperation in public health issues within Europe severely hampered the involvement of the ECDC in the European response to the 2014 Ebola outbreak.[8] Although the massive dimensions of the current crisis are not comparable to the 2014 Ebola outbreak, the restrictive political mechanism at play previously shows what might be standing in the way of a coherent response to the COVID-19 pandemic.

In January, 2020, the member states did not see the need for the EU to coordinate their responses, as they tended to underestimate the impact of the pandemic and the resources needed. However, the pandemic intensified within a very short period and became a large threat for the entire European population. Such a quick escalation became an obstacle to coordination at the EU level—a scenario where the ECDC could have been called to have a more active role, on behalf of the European Commission and the member states. The lack of coordination at the EU level became even more evident when national leaders sought to legitimise their decisions by giving voice to national experts, in the absence of multinational meta-analytical infrastructure or supranational coordination mechanisms, or even coherent systems for sharing procedures and protocols. The European Commission advisory panel on COVID-19 was set up by the EU member states as late as March 16, 2020.[9]

From a policy perspective, a European public health response to the COVID-19 pandemic was not possible because emergency structures had not been set up. Neither was it perceived to be a public good, not even when it spread across European countries. For instance, the creation of a strategic EU medical stockpile was approved by the Commission in March, 2019.[10] However, it was only implemented after WHO declared the outbreak a global pandemic on March 11, 2020, and several member states had difficulties in purchasing medical equipment.[11]

We have found that only when key actors in the EU polity agree on a common response that is less politically costly than disagreement can European-wide public health mechanisms such as the ECDC adopt a more active role. However, for this situation to occur, institutions need enough time to frame coordinated responses and a political leadership capable of going beyond national responses and confronting such global challenges in a more effective way.

We declare no competing interests.

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Department of Error

Clark H, Coll-Seck A M, Banerjee A, et al. A future for the world's children? A WHO-UNICEF–Lancet Commission. Lancet *2020;* ***395:*** *605–58*—In this Commission, the affiliation details for S Peterson, D B Hipgrave, and J Requejo were incorrect and have been changed to "UNICEF Headquarters, Programme Division, Health Section (S Peterson MD, D B Hipgrave PhD), and Division of Data, Analysis, Planning and Monitoring, Data and Analytics Section, New York, USA (J Requejo PhD)". Affiliation details for ZA Bhutta (Center of Excellence in Women and Child Health, the Aga Khan University, Karachi, Pakistan) have been added. In panel 1, the sentence "Country leaders on child health and child rights should push for the adoption of new protocols by the UN Convention" has been corrected to "Country leaders on child health and child rights should push for the adoption of new protocols to the UN Convention". The text "and Genevieve Begkoyian and colleagues at the UNICEF Lebanon Country Office and at the American University of Beirut contributed case studies of children in Lebanon." has been added to the Acknowledgments. The appendix has also been updated. These corrections have been made to the online version as of May 21, 2020.